DEPARTMENT OF HEALTH AND HUMAN SERVICES

# OFFICE OF INSPECTOR GENERAL

# Medicare Home Health Care Community Beneficiaries 2001


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INSPECTOR GENERAL

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# OFFICE OF INSPECTOR GENERAL

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# EXECUTIVE SUMMARY

## PURPOSE

To identify the population of Medicare home health beneficiaries coming from the community, to describe how they access home health care, and to identify any access issues.

## BACKGROUND

The home health care environment has undergone a great deal of change within the last few years. This inspection is part of a larger body of work that the Office of Inspector General (OIG) is conducting on Medicare home health services. For this study, we defined "home health community beneficiaries" as those patients that have not been in a hospital or skilled nursing facility in the 15 day period prior to the start of their home health care. First, we analyzed home health claims data from the Centers for Medicare & Medicaid Services (CMS) for each of the first quarters of 1997 through 2000. Secondly, we administered a mail survey to 501 Medicare home health beneficiaries. Finally, we interviewed 60 aging network representatives, 30 home health agencies, 21 physicians, and 10 home health hotline representatives for a total of 121 telephone interviews.

## FINDINGS

### About 40 percent of Medicare home health beneficiaries do not have a prior hospital or nursing home stay

Thirty-eight percent of Medicare beneficiaries who started home health care in the year 2000 had not been in a hospital or skilled nursing facility prior to getting home health care. We found variation across States in 2000 with regard to the percentage of Medicare "community beneficiaries." For example, 2000 data show that New Jersey had the lowest percentage of "community beneficiaries," 27 percent of all Medicare home health patients in that State, while the percentage in the State of Louisiana was 47 percent.

### Characteristics of "community beneficiaries" unchanged

We found only minimal change over time in the characteristics of "community beneficiaries" receiving home health services. The average age, gender ratio, racial distribution, and urban/rural designation all remained relatively constant between 1997 and 2000. In addition, the same five diagnoses remained in the top five ranking for home health beneficiaries who came from the community between 1997 and 2000. When comparing the diagnoses of "community beneficiaries" and hospital-discharged patients, we found some evidence that "community home health patients" have more chronic conditions.

## Beneficiaries accessing home health care from the community rely on multiple sources to obtain home health services

All respondents agree that doctors play the most prominent role in connecting "community beneficiaries" to home health services. However, they add that family or friends also play a role and that aging network representatives are sometimes instrumental in informing "community beneficiaries" about the availability of home health services.

## Overall, home health care appears to be accessible

The majority of physicians (18 of 21) and home health agencies (22 of 30) we spoke with report that all of the "community beneficiaries" who were eligible for Medicare home health services were able to get these services during the past year. In addition, aging network representatives did not report any major access problems; however, most of those who had contact with Medicare "community beneficiaries" point out that they generally do not know whether or not these beneficiaries eventually get home health services. While we did not find evidence of significant access problems for "community beneficiaries," some respondents expressed concerns about various aspects of home health care. Physicians, home health agencies, and aging network representatives all report anecdotal evidence that "community beneficiaries" with certain medical conditions are unable to obtain Medicare home health services. In most instances, we found the reported experiences of "community beneficiaries" to be similar to those discharged from the hospital into Medicare home health services.

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# INTRODUCTION

## PURPOSE

To identify the population of Medicare home health beneficiaries coming from the community, to describe how they access home health care, and to identify any access issues.

## BACKGROUND

The home health care environment has undergone a great deal of change within the last few years. This inspection is part of a larger body of work that the Office of Inspector General (OIG) is doing on Medicare home health services, and will add to the body work the OIG has done in this area (See Appendix A).

In particular, this inspection looks at how Medicare beneficiaries gain access to home health services in cases where they have not been in the hospital or a skilled nursing facility prior to home health care. An OIG inspection released in July 2001 looked at access to home health services for beneficiaries discharged from the hospital to Medicare home health agencies. The scope of that study was limited to hospital beneficiaries for methodological reasons. By relying on a wide variety of data sources, this study seeks to gather information on access to home health services for beneficiaries that have not had a recent stay in a medical facility.

### Medicare Home Health Care

Home health services consist of skilled nursing, therapy (physical, occupational and speech), and certain related services, including social work and aide services, all furnished in a patient's home. Services are typically provided by registered nurses, therapists, social workers, or home health aides employed by or under contract to a home health agency (HHA). These agencies can be free-standing or provider-based and are classified as not-for-profit, proprietary, or governmental.

Medicare will pay for home health care only if it is reasonable and necessary for the treatment of the patient's illness or injury. In order to be eligible for services, a beneficiary must be homebound, be under the care of a physician who has established a plan of care, **and** need at least one of the following intermittent and not full time skilled services: skilled nursing care, physical therapy, speech therapy, continued occupational therapy at the start of care. (Occupational therapy alone does not constitute a skilled need. However, after care has begun and other skilled services are discontinued, continued occupational therapy is a skilled need.) Home health aide visits are covered to the extent that the aide services support the skilled need of the beneficiary. There are no

specific limits on the number of visits or length of coverage and no co-payments or deductibles apply.

## Trends in Medicare Home Health Care

After a history of increases, Medicare home health expenditures have dropped since 1998. Between Fiscal Years 1991 and 1997, Medicare home health care annual expenditures rose from $4.7 billion to $17.6 billion. This was due to an increase in both number of beneficiaries receiving home health services and the number of visits they received. In 1998, however, spending for home health services began to drop and in Fiscal Year 1999 was about $8.7 billion. Furthermore, the average home health length of stay has declined from 98 days in 1997 to 58 days in 1999 and the number of beneficiaries served has decreased by 22 percent[1].

A number of factors have contributed to the recent decrease in Medicare home health spending. These include interim payment limits created by the Balanced Budget Act of 1997, as well as several initiatives that were implemented in response to concerns about fraud and abuse. Specifically, in 1996, the Health Insurance Portability and Accountability Act substantially increased financial support to the OIG's fraud control efforts.

### Prospective Payment System

The Balanced Budget Act of 1997 (BBA) required that the existing cost-based home health payment system be replaced with a prospective payment system (PPS) of fixed, predetermined rates on October 1, 2000. To allow time for HCFA to develop this prospective payment system, the BBA mandated an interim payment system (IPS) to limit payments. The IPS became effective for cost-reporting periods beginning October 1, 1997, and continued until PPS began on October 1, 2000. The IPS was intended to control the aggregate costs of services provided to beneficiaries in two ways. First, it subjected Medicare HHAs to a new payment limit that was based on an aggregate per-beneficiary amount. This limit was based on a blend of historical per-user costs for the agency and agencies in the region. It was applied to an agency's total Medicare payments and not to specific beneficiaries. Second, it decreased the per-visit limits from 112 percent of the national mean cost per visit to 105 percent of the national median. Medicare then paid HHAs the lower of their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

Prior to the implementation of IPS, home health agencies were reimbursed based on what it cost to provide services to Medicare beneficiaries. As a result there was a financial incentive for HHAs to provide more services than might be necessary. Under the new prospective payment system, financial incentives have changed somewhat. Because

[1]Comparisons are between the first 2 months of 1997 and the analogous period in 1999.

agencies are now paid fixed, pre-determined rates, there may be an incentive for home health agencies to limit the services provided within a given episode of care. As a result, Medicare beneficiaries receiving home health services may be at risk of receiving fewer services than in the past.

### Medicare Home Health Beneficiaries From The Community

For purposes of this study we are defining Medicare home health beneficiaries from the community as those patients that have not been in a hospital or skilled nursing facility in the 15 day period prior to the start of their home health care. Beneficiaries who have visited a hospital outpatient clinic but have not had an overnight stay will be considered from the community since, in many cases, these beneficiaries will not have had the benefit of hospital discharge planning services.

## Related Work

### Selected OIG Studies

The Office of the Inspector General has recently released a number of related inspections. *Access to Home Health Care After Hospital Discharge 2001*, OEI-02-01-00180, was released in July 2001. This inspection assessed access to home health services for Medicare beneficiaries discharged from the hospital. Eighty-nine percent of discharge planners report that under the prospective payment system they can place all of their Medicare patients who need care in home health agencies, however, some patients experience delays associated with certain medical conditions or service needs. Additionally, we found that, overall, the availability of home health services seems to be sufficient, even though the number of agencies has decreased. In conclusion, little evidence was found that the new prospective payment system is limiting beneficiaries' access to care. Similar inspections were conducted by the OIG in 2000 and 1999, at that time the interim payment system was in effect. Findings related to beneficiary access to home health services were similar. In addition, the OIG recently released two studies that included surveys of beneficiary and physician perspectives on Medicare home health services.[2]

Earlier OIG work on Medicare home health services includes two other related studies, both of which addressed the adequacy of home health services. There have been some concerns about the adequacy of services in light of recent significant decreases in Medicare home health care expenditures. In response to these concerns, the OIG evaluated hospital re-admission and emergency visit rates and looked at home health agency survey and certification deficiencies. Data from these studies indicate that there

[2]"Medicare Home Health Beneficiary Survey," OEI-02-00-00560 and "The Physician's Role in Medicare Home Health Care: A Follow-up," OEI-02-00-00620.

have not been significant increases in re-admissions or emergency room visits for home health care patients. In addition, we found that, overall, home health agency deficiencies increased 26 percent between the first 6 months of 1997 and the first 6 months of 1999, but that there is no single explanation for this growth.

**Other Work**

Several other studies have examined access to home health care for Medicare beneficiaries, although, as noted earlier, none that we found focused exclusively on beneficiaries from the community. The tendency has been toward gathering information about beneficiaries who start home health after having been in a medical facility such as a hospital.

A 1999 report by the General Accounting Office found that although about 14 percent of HHAs have closed since 1997, there is little evidence that appropriate access to care has been impaired. The study found that closures occurred most frequently in areas that had experienced considerable growth.

Also in 1999, a two-part study released by George Washington University (GWU) entitled, *An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care*, found that the majority of HHAs participating in the study in eight States altered their case mix and/or practice patterns to conform utilization to IPS reimbursement. The second phase of the GWU study found hospital discharge planners reporting more difficulty in obtaining home health services for Medicare beneficiaries. Most attributed these increases to changes in admitting and practice patterns by HHAs, changes in staffing patterns, or the effects of agency closures in their service area.

Similarly, the 1999 study sponsored by the Medicare Payment Advisory Commission contained survey information from HHAs and entailed panel discussion information on the issue of access with health professionals, attorneys, and advocates. The report found that many HHAs have adopted new admission and discharge practices since IPS.

Finally, two 1999 reports based on early data from CMS's Per-Episode Home Health Prospective Payment Demonstration suggest that prospective payment can lower Medicare home health costs without harming quality of care. The first report found no evidence that quality of care as measured by patient outcomes was adversely affected. The second report concluded that although the per-episode prospective payment demonstration substantially reduced home visits, it did not suggest that quality of care was affected.

## METHODOLOGY

We obtained data for this study from a number of sources. We analyzed CMS claims data and administered surveys to a number of different respondent groups.

### Analysis of Claims

#### Data Analysis Universe Selection

We selected all CMS home health claims for each of the first quarters of 1997, 1998, 1999, and 2000. One hundred percent of final clams were used for 1997-2000. These claims were cross matched against hospital and skilled nursing facility claims to identify Medicare beneficiaries who had a stay in either of these facilities within the 15 day period preceding the start of their home health services. Those beneficiaries who did not have a match were coded as "from the community."

The universe was limited to the first episode for each beneficiary for a given year, making the unit of analysis a beneficiary. For the purposes of this data analysis, a new episode is defined as beginning when a gap of over 30 days exists between an HHA claim "service from date" and the prior claims "service thru date" for a given beneficiary. In addition, if a beneficiary had both a hospital stay and a SNF stay within the 15 day period preceding their HHA episode and the SNF stay was more recent, they were coded as a beneficiary with a recent SNF stay. Therefore, a beneficiary could only be counted one time in any given year, however, they could show up in more than 1 year.

#### Data Analysis

Selection of this sample enabled us to determine the current proportion of Medicare beneficiaries "from the community"-- those admitted to home health services without a recent hospitalization or SNF stay. Using these data we also analyzed whether the proportion of "community beneficiaries" differs across States. Finally, these data were analyzed to determine what proportion of home health beneficiaries came from the community in an earlier period (first quarter of 1997).

In addition, we used HHA claims data, including ICD-9 diagnosis data, to a build a profile of Medicare home health patients who come from the community. Specifically, we looked at the most common home health diagnoses, age, sex, race, and urban-rural designation. Using CMS National Claims Data, we compared this profile to previous years to ascertain what, if any, change had occurred. We also compared the diagnoses of "community patients" to those discharged from the hospital to home health services. Diagnosis related groups (DRGs) were used as a proxy for diagnosis for hospital-discharged patients.

The first quarter of 1997 was chosen as the earliest comparison period for our data analysis because the interim payment system (IPS) was not yet in effect. At that time providers were being paid on a cost basis, as they had been for many years, as opposed to being reimbursed based on fixed pre-determined rates. It should be noted that the latest comparison period we look at, first quarter of 1999, reflects data associated with a fully implemented interim payment system, however, it pre-dates the October 1, 2000 implementation of the prospective payment system (PPS).

## Beneficiary Sample for Mail Survey

Using the CMS National Claims History File, all Medicare beneficiary HHA claims for services started within the period January 7-12, 2001, were identified. A random sample of 700 beneficiaries was selected. Since this was a random sample, we expected the proportion of respondents who received home health services without a recent hospitalization or SNF stay to be approximately the same proportion as it is in the universe at large. We received completed mail questionnaires from 501 beneficiaries in all. This was the same sample we used in a related OIG inspection entitled *Medicare Beneficiary Home Health Survey*, OEI-02-00-00560.

## Sample Selection For Telephone Interviews

We chose a purposive sample of the 10 States with the highest number of home health beneficiaries coming from the community. In the year 2000, 52 percent of the population of "community beneficiaries" resided in these 10 States. In addition, these States provide representation across different geographic regions and include States with long-standing and active aging programs as well. The 10 States are: California, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, North Carolina, Pennsylvania, and Texas. With the exception of the beneficiary mail survey, all respondents were from these 10 States. We administered telephone surveys to each of the respondent groups identified below. Telephone interviews were conducted during April and May of 2001.

### Respondents From 10 State Sample

**Physician Sample, 21 Interviews.** We pulled a simple random sample of physicians within the 10 States. Using the CMS National Claims History File to identify Medicare beneficiary HHA claims for services provided during the last 6 months of 2000, we eliminated beneficiaries whose records showed a hospital or SNF stay within the 15 day period prior to their home health services, and identified physicians who signed a home health plan of care associated with the remaining HHA claims. We then selected a random sample of physicians from those who signed 2 or more home health plans of care during the last 6 months of 2000.

**Home Health Agency Sample, 30 Interviews.** Using CMS's OSCAR and National Claims History data, we pulled a simple random sample of Medicare home health agencies that was large enough to ensure that we were able to hold discussions with 30 agencies. All agencies in our 10 State sample that had submitted claims in the last 6 months of 2000 were included in our universe.

**State Unit on Aging (SUA) Sample, 10 Interviews.** We identified and interviewed the State Unit on Aging director in each of the 10 States. SUA directors, who operate at the State level, were asked questions about emerging trends affecting Medicare beneficiaries seeking home health services.

**State Health Insurance Program (SHIP) Sample, 10 Interviews.** We identified and interviewed the State Health Insurance coordinator (commonly referred to as SHIP coordinators) in each of the 10 States. SHIP co-ordinators, who operate at the State level, were also asked questions about emerging trends affecting Medicare beneficiaries seeking home health services. The SHIPs are staffed with volunteers whose function it is to provide guidance on health insurance options for older Americans.

**Area Agencies on Aging (AAA) Sample, 20 Interviews.** In each of the 10 States we identified and interviewed two AAA representatives. These respondents were identified by State-level program directors. Because these local agencies are known to have a significant amount of hands-on experience with Medicare beneficiaries, we relied on them to provide information on the actual experiences of Medicare beneficiaries attempting to access Medicare home health services from the community.

**Local State Health Insurance Program (Local SHIP) Sample, 20 Interviews.** In each of the 10 States we identified and interviewed two local SHIP representatives. These respondents were identified by State-level SHIP co-ordinators. Because these agencies are known to have a significant amount of hands-on experience with Medicare beneficiaries, we relied on them to provide information on the actual experiences of Medicare beneficiaries attempting to access Medicare home health services from the community.

**State Home Health Hotline Sample, 10 Interviews.** We identified the State home health hotline representative in each of the 10 States. Each State is required to have a home health hotline set up to handle questions and complaints. The hotline provides services ranging from home health agency referrals to investigation of complaints against an agency. We asked hotline representatives general questions seeking to gain any knowledge they might have pertinent to "community beneficiary" access to home health services. In total we conducted 121 telephone interviews.

## Limitations

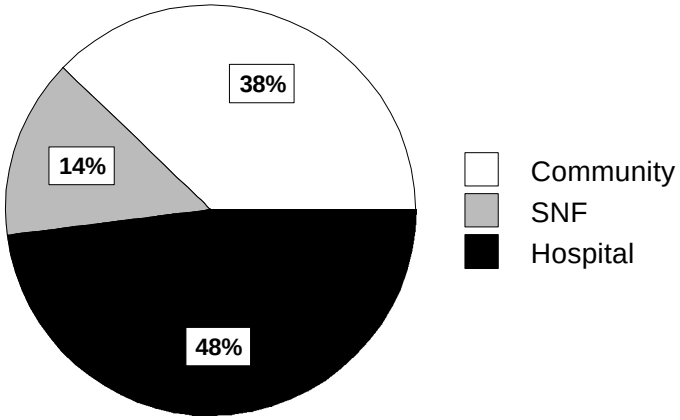
For purposes of our trend analyses, we used CMS claims data for a 3 month sample time frame (January- March) to project to the balance of the year. To the extent that claims in the first 3 months of a given year differed substantially from the balance of the year, they are not represented in our analyses. In addition, it should be noted that this study focuses exclusively on Medicare home health services provided to fee-for-service Medicare patients and, therefore, does not address the experiences of Medicare home health patients who are enrolled in a Medicare + Choice managed care plan (approximately 15 percent of the Medicare beneficiary population).

# FINDINGS

## About 40 percent of Medicare home health beneficiaries do not have a prior hospital or nursing home stay

We found that 38 percent of Medicare beneficiaries who started home health services in the year 2000 had not been in a hospital or skilled nursing facility prior to getting home health care[3]. (See Figure 1 below.) One characteristic that differentiates these patients, who come directly from the community, is that they do not have the benefit of discharge planning services. This difference can have a number of impacts. First, "community home health beneficiaries" often have less access to information about the Medicare services for which they may be eligible. Additionally, they may not know what process they need to follow to obtain services. Finally, they are likely to be without the benefit of a home health agency referral list, which most discharge planners are required to provide to prospective home health patients.

**Figure 1**
**Proportion of Medicare Beneficiaries in Home Health Care by Referral Source - 2000**




Source: National Claims History File, first quarter data

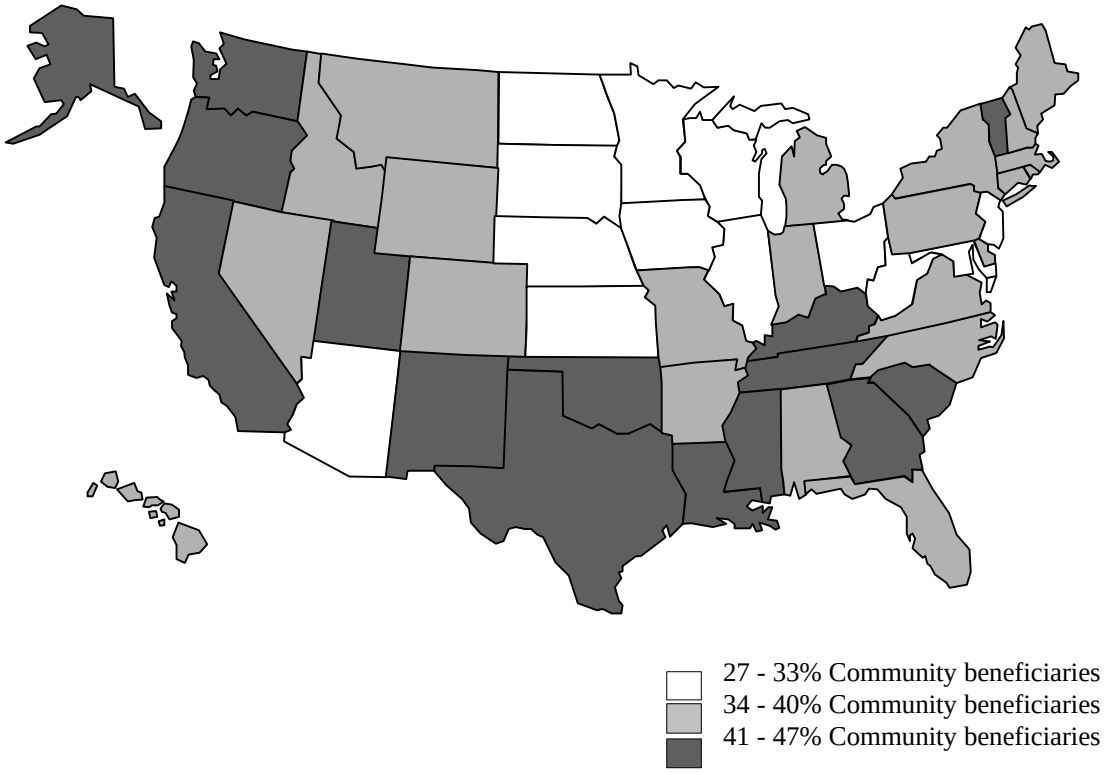
[3]Within the 15 day period prior to the start of their home health services. Percentages are based on a 3 month sampling time frame-- January 1, 2000 - March 31, 2000. Projection to the full year is based on the assumption that claims during the first 3 months are similar those submitted throughout the balance of the year.

The total number of beneficiaries who received home health services in the first quarter of 1997 was 848,990. In the first quarter of 2000 this number was 733,410. During this period the proportion of Medicare "community beneficiaries" decreased by a small amount. We found that in the first quarter of 1997, 41 percent of Medicare home health patients had not been in the hospital or a skilled nursing facility prior to starting services. In the first quarter of 2000, this number had dropped slightly to 38 percent.

## Percentage of "community home health beneficiaries" varies across States

There is variation across States in 2000 with regard to the percentage of Medicare home health patients that begin services without a prior hospital or skilled nursing facility stay, as Figure 2 below indicates.

**Figure 2**
**Variation in the Proportion of**
**"Community Home Health Beneficiaries" by States in 2000**




Source: National Claims History File, First Quarter Data

For example, New Jersey had the lowest percentage of "community beneficiaries"-- 27 percent of all Medicare home health patients in that State[4], while the percentage of "community beneficiaries" in the State of Louisiana was 47 percent. The range between the States with the highest and lowest percentages of "community beneficiaries" is similar in earlier years. Medicare claims data show that in 1997 the lowest percentage was 27 and the highest was 53 percent. It is important to keep in mind that there are many factors that may influence these statistics. For example, the extent to which community-based aging programs are available in a given area may affect the proportion of "community home health beneficiaries." Other factors like the number of home health agencies and skilled nursing facilities in a given State may affect the proportion of "community beneficiaries" as well.

## Characteristics of "community beneficiaries" unchanged

We found only minimal change over time in the characteristics of "community beneficiaries" receiving home health services. In 1997, the average age of a community home health beneficiary was 78. In 2000, the average age was 79. Sixty-seven percent of "community beneficiaries" were women in 1997, while 33 percent were men. This gender ratio remained constant in 2000. In addition, the racial distribution of "community beneficiaries" changed very little between 1997 and 2000.

There has also been little change in the geographic distribution of "community beneficiaries." In 1997, 74 percent lived in an urban area, while 26 percent lived in a rural area. In 2000, one percent more "community beneficiaries" lived in an urban area.

### Top five diagnoses for community home health beneficiaries remain the same

As shown in Figure 3 on the next page, the same five diagnoses remained in the top five ranking for home health beneficiaries who came from the community between 1997 and 2000. However, the ranking of these diagnoses changed somewhat beginning in 1999. Proportionately more "community beneficiaries" with chronic ulcer of the skin received home health care in 1999 and 2000. This may indicate a recent increase in access for patients requiring wound care. The top five diagnoses in Figure 3 represent approximately 25 percent of the "community beneficiary" population.

[4]Percentages are based on a 3 month sampling time frame-- January 1, 2000 - March 31, 2000.

**Figure 3**
**Ranking of Highest Volume Diagnoses For**
**"Community Beneficiaries" By Year**

| Primary ICD9 Diagnosis | Percent (rank) 1997 | Percent (rank) 1998 | Percent (rank) 1999 | Percent (rank) 2000 |
|---|---|---|---|---|
| 250- Diabetes | 8.6 (1) | 7.6 (1) | 6.9 (1) | 6.2 (1) |
| 401- Essential hypertension | 7.7 (2) | 6.2 (2) | 5.5 (3) | 5.3 (3) |
| 428- Heart failure | 5.3 (3) | 5.0 (3) | 4.7 (4) | 4.6 (4) |
| 707- Chronic ulcer of the skin | 3.6 (4) | 4.6 (4) | 5.7 (2) | 5.6 (2) |
| 715- Osteoarthrosis | 3.2 (5) | 3.3 (5) | 3.2 (5) | 3.6 (5) |

Source: National Claims History File, first quarter data

## Some evidence that "community home health beneficiaries" have more chronic conditions than hospital-discharged patients

In order to determine if "community home health beneficiaries" differ from beneficiaries who come from the hospital, we compared the diagnoses of home health beneficiaries discharged from the hospital with the diagnoses of beneficiaries who came into home health care directly from the community. For the year 2000, we found the top five diagnoses[5] for hospital-discharged home health beneficiaries were: coronary bypass, respiratory infections and inflammations, specific cerebrovascular disorders, major small and large bowel procedures, and chronic obstructive pulmonary disease. When comparing these diagnoses to those of home health beneficiaries who came directly from the community, we find some evidence that, overall, "community home health beneficiaries" have more chronic conditions. For example, the top five diagnoses for "community home health beneficiaries" include chronic conditions such as diabetes, essential hypertension, and chronic ulcer of the skin. In contrast, hospital diagnoses such as coronary bypass, specific cerebrovascular disorders, and major small and large bowel procedures are more acute in nature. Supporting this, 19 of the 30 home health agencies we spoke with report that their patients who come from the hospital are "sicker" than those who come from the community.

[5]Based on hospital DRG codes

## Beneficiaries accessing home health care from the community rely on multiple sources to obtain home health services

### Doctors play primary role

All respondents agree that doctors play the most prominent role in connecting "community beneficiaries" to home health services. When we asked "community beneficiaries" how they found out about the home health agency they are using, the most common response was "through my doctor." Similarly, 46 out of 60 aging network representatives we interviewed name physicians as the source that usually refers beneficiaries for services. Fifteen out of 21 physicians that we spoke with also state that they most often inform "community home health beneficiaries" about the availability of home health services. Home health agencies agree that "community beneficiaries" most often find out about home health services through their physician. However, they add that family or friends also play a role and that aging network representatives are sometimes instrumental in informing "community beneficiaries" about the availability of home health services.

### Aging network also provides assistance

Over half (37 of 60) of State and local aging network representatives that we spoke with report that "community beneficiaries" contact their office for help in obtaining Medicare home health services. Of those that are contacted, 76 percent report that they provide assistance either sometimes or frequently. During a recent 6 month period, aging network representatives report receiving, on average, 55 telephone calls from "community beneficiaries" needing home health services. When contacted by "community beneficiaries," the aging network representatives generally conduct an assessment of the beneficiary's needs. Sometimes they assist them in locating a home health agency, refer them back to their physician, or give them general information about home health.

## Overall, home health care appears to be accessible

Most physicians (18 of 21) report that all of their patients who both need and are eligible for Medicare home health services are able to get that care. The other physicians say that a few of their patients could not get care. The majority of home health agencies (22 of 30) we spoke to told us they were able to serve all patients who both needed and were eligible for Medicare home health care. Most of those who could not serve all patients noted that the number who could not be served has not changed in recent years. In addition, aging network representatives did not report any major access problems.

However, most aging network representatives who had contact with Medicare "community beneficiaries" point out that they generally do not know whether or not these beneficiaries eventually get home health services.

While we did not find evidence of significant access problems for "community beneficiaries," some respondents expressed concerns about various aspects of home health care. Those concerns centered around such things as medical conditions, Medicare eligibility and coverage, and home health agency staffing shortages. Some physicians (7 of 21) report anecdotal evidence that "community beneficiaries" with medical conditions such as diabetes, wound care, and Alzheimer disease are unable to obtain Medicare home health services. About a third of the home health agencies we spoke with (12 of 30) also report that there are some services they are unable to provide to Medicare patients and approximately a third of the aging network representatives (23 of 60) report that there are some medical conditions that affect the ability of "community beneficiaries" to get services.[6] Additionally, some physicians, home health agencies and aging network representatives report other factors that affect access. For example, six home health agencies report that staffing issues sometimes affect their ability to provide services. Examples of other obstacles aging network representatives (30 of 60) mention include: lack of knowledge about Medicare home health services; home health agency staffing shortages; Medicare reimbursement policies; and physicians being more cautious in ordering Medicare home health care for patients.

When asked what happens to "community beneficiaries" who are unable to get home health services, physicians respond that patients go without care, go into the hospital, or are visited at home by their physician without having the benefit of Medicare home health services. Home health agencies agree that "community beneficiaries" who cannot find home care most often go without services or go into a nursing home. Some local aging network representatives point out that a portion of "community beneficiaries" are able to find alternatives to Medicare home health services through charitable or community grant programs.

Thirteen of the 21 physicians we spoke with report a change in access over the past 5 years for "community beneficiaries." Five of these physicians note that access has improved. Comments from the remaining eight physicians include the following: that access has decreased because of tightened Medicare eligibility requirements, visits are shorter than they used to be, and fewer home health services are being provided to Medicare beneficiaries. The remaining eight physicians said there had been no change in access for "community beneficiaries" over the past 5 years.

In most instances we found the reported experiences of "community beneficiaries" to be similar to those discharged from the hospital into Medicare home health services. We asked 501 Medicare beneficiaries who are receiving home health services whether they

[6]It should be noted that patients with chronic conditions are not eligible for Medicare home health care if they do not meet the skilled need eligibility criteria.

had difficulty finding a Medicare home health agency to accept them and whether any agency had refused to accept them. Over 95 percent of both "community" and "hospital-discharged" beneficiaries say they experienced no problems in either regard. We also asked if the agency providing their services was their first choice. Again, the majority said "yes" and there was no significant difference in the reported experiences of "community" and "hospital-discharged" beneficiaries. The only significant difference we found was that more "community beneficiaries" report that they only had one agency to choose from (70 percent versus 55 percent).

# SUMMARY

We found that the characteristics of "community home health beneficiaries," including the most common diagnoses, have generally remained the same over the course of the last few years. There is some evidence that "community beneficiaries" have more chronic conditions than hospital-discharged patients. Through reliance on their physicians, family, and the aging network, they appear to be getting access to Medicare home health care, however, a minority of respondents expressed some concerns such as barriers for Medicare patients with certain medical conditions, confusion regarding Medicare eligibility and coverage, and home health agency staffing shortages. In most instances, we found the reported experiences of "community beneficiaries" to be similar to those discharged from the hospital into home health services.

**APPENDIX A**

## Selected List of Recent Office of Inspector General Home Health Inspections

Office of Inspector General, US Department of Health and Human Services, "The Physician's Role in Medicare Home Health 2001," OEI-02-00-00620, August, 2001.

Office of Inspector General, US Department of Health and Human Services,"Medicare Beneficiary Experiences with Home Health," OEI-02-00-00560, July, 2001.

Office of Inspector General, US Department of Health and Human Services, "Access to Home Health Care After Hospital Discharge 2001," OEI-02-01-00180, July, 2001.

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**APPENDIX B**

## Confidence Intervals For Key Findings

We calculated confidence intervals for key findings in the beneficiary survey. The point estimate and 95 percent confidence interval are given for each of the following:

| KEY FINDINGS | N | POINT ESTIMATE | |
|---|---|---|---|
| When we asked "community beneficiaries" how they found out about the home health agency they are using, the most common response was "through my doctor." [7] | 158 | 63% | 56% - 71% |
| We asked Medicare beneficiaries who are receiving home health services whether they had difficulty finding a Medicare home health agency to accept them... | | | |
| "Community" | 152 | 95% | 92% - 99% |
| "Hospital-discharged" | 278 | 99% | 98% - 100% |
| We asked Medicare beneficiaries who are receiving home health services whether... any agency had refused to accept them. | | | |
| "Community" | 141 | 96% | 93% - 99% |
| "Hospital-discharged" | 253 | 99% | 98% - 100% |

[7] This was a "check all that apply" question, therefore, respondent answers will add to over 100 percent for this question.

**APPENDIX C**

## Chi-Square Test for "Community"/"Hospital-Discharged" Beneficiaries

We computed Chi-square values for differences between the experiences of "community" and "hospital discharged" beneficiaries who gained access to home health services. All variables were analyzed at the 95 percent confidence level.

| VARIABLE | Degrees of Freedom | Chi-Square | Probability | Significant? |
|---|---|---|---|---|
| The only significant difference we found was that "community beneficiaries" were slightly more likely to say that they did not have more than one agency to choose from (70% versus 55%). | 1 | 7.54* | .01 | Y |

*Statistically significant at the 95 percent confidence level.